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Western North Carolina Community Health Services, Inc. (WNCCHS) is pleased to provide comments on the North Carolina Medicaid and NC Health Choice Section 1115 Demonstration Waiver Application that was submitted by the North Carolina Department of Health and Human Services (NC DHHS) to the Centers for Medicare and Medicaid Services (CMS) on June 1, 2016.

WNCCHS is a federally qualified health center (FQHC) organization that provides comprehensive primary care services to the medically underserved at two sites in Buncombe County, North Carolina. As a community health center, we serve all patients regardless of ability to pay, and in 2014 we served 14,480 patients including almost 3,000 Medicaid patients and 8,350 uninsured patients. Along with North Carolina's 37 other community health centers, we form the backbone of North Carolina's safety net and its Medicaid primary care providers. We are by statute and by mission required to serve Medicaid and NC Health Choice patients, and we therefore have a vested interest in ensuring that the Medicaid program maintains accessibility for patients and providers alike, sustainability, and integrity throughout the transformation process. However, we have several significant concerns regarding the waiver application as submitted by the State, and we urge CMS to consider the following comments.

Expand Medicaid to Improve Access and Health Outcomes

CMS should encourage the State of North Carolina to expand Medicaid by extending insurance coverage options to all adults ages 18-64 with incomes at or below 138% of the Federal Poverty Level.

The 1115 Demonstration Waiver submitted by NC DHHS lacks the most important health policy change needed to improve access and quality of care for North Carolinians and strengthen the provider community — Medicaid expansion as called for under the Affordable Care Act. Medicaid coverage should be extended to all adults ages 18-64 with incomes at or below 138% of the Federal Poverty Level (FPL). In North Carolina, expanded Medicaid would cover more than 400,000 people; at least 244,000 of those in the Coverage Gap are uninsured as a result.ⁱ

In 2014, 43% of all FQHC patients in North Carolina were uninsured and more than 70% of patients lived at or below 100% FPL. FQHC providers see firsthand the significant health challenges and barriers to needed services that these uninsured and low-income patients face. In North Carolina, nearly 40,000 women are not receiving recommended preventive screenings, 27,044 diabetics cannot get much needed medications, and 45,500 individuals with depression are not getting the treatment they need.ⁱⁱ In fact, providers often have to modify treatment plans for uninsured patients because of their inability to afford a specialist visit or pay for needed medications.

North Carolina community health centers estimate statewide health center revenues would increase by up to \$35 million if the state increased access to affordable insurance for low-income populations. If Medicaid were expanded, WNCCHS could expand critical services, including mental health and dental services. Studies have shown that health centers in states that did expand Medicaid were significantly more likely to have expanded dental and mental health services than those health centers in states that did not expand Medicaid. Dental and mental health services continue to be in very high demand in western North Carolina.

A policy brief from the Georgetown Center for Children and Families finds that federally qualified health centers and safety net hospitals in states that expanded Medicaid see fewer uninsured patients, provide less uncompensated care, and experience more budget savings compared to their peers in states that have not expanded the program.ⁱⁱⁱ The report highlights research showing health centers experience decreases in uninsured visit rates drop by as much as 40% following Medicaid expansion. These budget savings have provided the safety net with more flexibility to expand their sites and services, hire new staff, update clinical and medical equipment, and integrate and improve the care they provide.^{iv} For example, health centers in expansion states were significantly more likely than those in non-expansion states to report having expanded their capacity for dental and mental health services since the start of 2014.^v Health centers in our state remain hampered from expanding their efforts to innovate and improve their practices due to a lack of funding streams to support them. Under Medicaid reform as proposed by this Waiver application, our state will not achieve such levels of integrated care without expanding access to coverage for the remaining uninsured population in our state.

Develop a Plan to Replace Eliminated Resources and Services

CMS must require the North Carolina Department of Health and Human Services to articulate how they will maintain current levels of investment to primary care providers for integrating on-the-ground, Medicaid case management services in their practices.

The State claims that it plans to build upon the successes of North Carolina's nationally acclaimed enhanced primary care case management program, Community Care of North Carolina (CCNC). However, the Waiver eliminates this program entirely from the new system without any articulated model to replace the services it provides. The CCNC program provides FQHCs and other primary care providers with vital financial support to integrate case management services that address Medicaid beneficiary needs. Federally qualified health centers served more than 144,000 Medicaid beneficiaries in 2015 and stand to lose at least \$5.6 million in PMPM payments for case management services under the current Waiver proposal.

The Waiver fails to explain how the newly-developed Person-Center Health Communities (PCHCs) or Prepaid Health Plans (PHPs) will continue current levels of financial support for case management services. We question whether the PHPs replacing CCNC will be willing to provide primary care providers with resources to continue critical on-the-ground case management services so our providers can offer the same quality of care and achieve comparable savings.

We ask the Centers for Medicare and Medicaid Services to demand North Carolina Department of Health and Human Services make a commitment and present a clearly articulated plan for how the State plans to ensure current levels of financial support to for case management services among primary care providers are retained in the transitioned Medicaid program.

Additionally we respectfully request the Centers for Medicare and Medicaid Services address FQHC and RHC Medicaid Prospective Payment System (PPS) Alternative Payment Methodology (APM) rates. These rates are inappropriately suppressed because of North Carolina's failure to follow all federal guidelines with respect to FQHC/RHC PPS rates.

In addition to the preceding, we would like to echo the comments of the North Carolina Community Health Center Association, which is the state primary care association of which we are a member. Please see their comments for additional details.

Thank you for considering our comments. Any questions about the preceding should be directed to:

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ⁱ Dorn, S., McGrath, M., Holahan, J. (August 2014). What is the Result of States Not Expanding Medicaid? Robert Wood Johnson Foundation & Urban Institute. Retrieved from: <http://www.urban.org/UploadedPDF/413192-What-is-the-Resultof-States-Not-Expanding-Medicaid.pdf>

ⁱⁱ Dickman, S., Himmelstein, D., McCormick, D., and Woolhandler, S. *Opting Out of Medicaid Expansion: The Health and Financial Impacts*. (January 30, 2014). Health Affairs Blog. Available online at: <http://healthaffairs.org/blog/2014/01/30/opting-out-of-medicaid-expansion-the-health-and-financial-impacts/>.

ⁱⁱⁱ Georgetown University Health Policy Institute Center for Children and Families. (June 2016). *Beyond the Reduction in Uncompensated Care: Medicaid Expansion Is Having a Positive Impact on Safety Net Hospitals and Clinics*. Retrieved from: http://ccf.georgetown.edu/wp-content/uploads/2016/05/Medicaid_hospitals-clinics-June-2016.pdf

^{iv} Ibid.

^v Ibid.